Jeanne Martin, LPC
1020 E. Jefferson St.
Charlottesville, VA 22902
434-984-3111

PATIENT REGISTRATION

(all information is confidential)

Name: _____

Birthdate: _____Social Security Number: _____

Address: _____

City/State: _____Zip: _____

Phone(s): _____

Email Address for administrative matters: _____

Please check one: _____single _____married _____separated _____divorced _____widowed _____partnered

Name of spouse or partner: _____

Spouse's Employer_____ Phone(s): _____

IF YOU ARE A STUDENT, PLEASE GIVE YOUR HOME ADDRESS AND PHONE:

Parent's Name(s): _____ Married: Y / N

Phone(s): (_____)_____

Address_____City/State_____Zip_____

EMERGENCY CONTACT(s)

Name_____Relationship_____

Mobile Phone(s) _____/_____ Work Phone _____/_____

REFERRED BY_____

Please initial if we have your permission to thank this person: _____

DATE_____

_____
Office Use

BILLING AND INSURANCE INFORMATION

(please check one):

_____ I prefer not to use health insurance and will pay expenses privately. (Please move to next page.)

_____ I request that my health insurance be billed for services provided.

In order to better process your claims, please provide the following information. We also ask to make a photocopy of your insurance card. Complete all items that apply to you.

Person responsible for payment *if different from Registration*_____

Address_____City/State_____Zip_____

Insurance Co_____Policy effective since_____

ID#_____Group #_____Contract #_____

Policy Holder, if not patient_____

SSN_____DOB_____Employer_____

If your mental health benefits require PREAUTHORIZATION, have you called for this?_____

I understand sessions not authorized will be billed to the patient. The number to call for authorization is on the back of your insurance card.

HEALTH AND MEDICAL INFORMATION

Primary reason(s) for this consultation:

_____

_____

_____

Previous psychological/psychiatric treatment or counseling, including inpatient:

Provider Begin/Ending Dates Approximate Amount of Visit(s) City/State

_____

_____

_____

Primary Care Physician: _____ Location/Phone: _____

Is your doctor aware of this consultation? *Yes*_____*No*_____

Specialty Physician(s):_____For:_____

_____

Allergies/Drug Reactions: _____

Current Medical Problem **Medication(s):** **Dose (if known):** **Prescribing MD:**

Began: _____

_____

Past Medication (s): _____

Past Major Medical Problems: **Ended:** **Medication(s):** **Prescribing MD:**

_____

All current medications (including over-the-counter, herbals, etc.) and dosage(if known): _____

_____

Do you smoke cigarettes, cigars, or use smokeless tobacco? _____

How many alcoholic drinks do you have in a week? ____ Are you concerned about your drinking? _____

Are there any other health/medical/emotional problems or concerns not addressed: _____

_____

_____

AGREEMENTS

Your co-payment or full fee is due at each visit, unless other arrangements are made. Insurance is billed at the end of each month as a service to our patients. Statements will be sent to you monthly. The billing service is available to assist you with questions about your coverage, the billing process, or a specific bill. The billing service's telephone number is (434) 971-4747 extension 100.

FEES

Initial Evaluation (50-60 min):	$160	
Individual Session (45-50 min):	$150	Report Preparation (per half hour): $100
Extended Session (90 min):	$225	Less than 24 hour cancellation/missed appointments: $125

AGREEMENTS

Please read each of the following statements carefully and initial each one. Sign your name and the date at the bottom. The secretary is available to answer any questions.

_____ **I authorize the following: 1) the release of any medical information necessary to process my insurance claim(s), 2) completion of treatment plans if required by my insurance company, and 3) payments from insurance to be made directly to provider.**

_____ **I understand that my insurance claim(s) will be filed for me, but that I am ultimately the responsible party for payment of my account regardless of insurance coverage.**

_____ **Providers must be informed immediately about any changes in insurance coverage. I understand I am responsible for payment for services provided, after a change in coverage.**

_____ **I understand that all bills are due at the time of receipt. Any bills not paid within 60 days of the date of billing will have an interest charge of 15% (per annum) unless other arrangements have been made. I agree to be responsible for attorney's or collection fees in the event my account is turned for collection.**

_____**I understand that appointments not canceled with a minimum of 36 hours in advance will be billed at FULL FEE. Missed appointments are NOT covered by insurance.**

_____**I understand that information will not be released unless authorized by me, required by law and/or court order, or where serious safety issues are involved. In the case of child, elderly, or compromised individuals abuse or neglect, a report will be made to the Department of Social Services. If there are concerns about patient's or other's safety, steps will be taken to insure safety of client or other relevant parties.**

_____**I consent to psychological treatment.**

I HAVE READ THE INFORMATION AND AGREE TO THE FEES AND POLICIES WHICH I HAVE INITIALED ABOVE.

Signed_____**Date**_____

Patient Name: _____

Birth Date: _____

Acknowledgement of Receipt of PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received a copy of the Notice of Privacy Practices For Protected Health Information, effective 4/14/2003.

Signature (patient): _____

Date: _____

Relationship/authority (if signed by authorized representative:_____

CONSENT to Use and Disclose Your HEALTH INFORMATION

I agree that Protected Health Information can be used in accordance with the Notice of Privacy Practices for Protected Health Information I received, and applicable federal and state laws, in the provision of treatment, to arrange payment, and for other business or government purposes. I understand I have the right to request restriction or limitation on the use and disclosure for treatment, payment, or administrative purposes. I also understand I have the right to revoke this consent (by writing a letter to the clinician or Privacy Officer); the effective date for non-disclosure begins with the day such letter is received.

Signature (patient): _____

Date: _____

Relationship/authority (if signed by authorized representative:_____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment is to your privacy. We are dedicated to maintaining the privacy of your personal health information as part of providing professional care. When we examine, diagnose, test, treat, or refer you, we will be collecting what the law calls Protected Health Information. We are required by law to keep your information private. We are also required by law to provide you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect.

Primary uses and disclosures of health information include the following:

For treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

For payment: We may use or disclose your medical information so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or another third party. We may also tell your health plan about treatment that you are going to receive, to obtain prior approval or to determine whether your plan will cover treatment.

For health care operations: We may use or disclose your health information in connection with our health care operations. These include quality assessment and improvement activities, certification, licensing or credentialing activities, participation in managed care plans, defense of legal matters, or business operations and planning.

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization form to allow this.

Other uses and disclosures: There are times we may also use or disclose your health information in accordance with federal and state laws.

As required by law: We may use or disclose your health information when we are required to do so by law, such as complying with a court subpoena or warrant and for other law enforcement purposes.

Abuse or neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that there is a serious threat to your health or safety, or the health and safety of another individual, or to the public. We will only share information to the extent necessary to avert a serious threat to your health and safety, or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence or other national security activities.

Worker's Compensation: We may disclose medical information about you for workers' compensation or similar programs.

Health Oversight Agency: We may disclose medical information to a health oversight agency for activities authorized by law.

Your rights regarding your health information:

You have the right to request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment or healthcare operations. If you request disclosure of information to another party, you may limit the information to be disclosed. To request restrictions, you must make your request in writing. In your request, you must state (1) what information you want to limit; (2) whether you want to limit my use, disclosure, or both; and (3) to whom you want the limits to apply. However, we are not required, by law, to agree with your request.

You have the right to request an amendment of your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your requests for certain specific reasons, and, if denied, we will provide you with a written explanation for the denial and information regarding further rights you would have at that point.

You have the right to receive communications in a confidential manner.

You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years (but not before April 14, 2003). If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing. Your request must specify the alternate means or location, and provide satisfactory explanation how payments will be handled under the alternate means or location your request.

You have the right to request a paper copy or additional copies of this Notice of Privacy Practices.

Complaints. If you think we have not properly respected the privacy of your health information, you are free to complain to us or the United States Department of Health and Human Services. You will not be penalized in any manner for a complaint. If you want to complain, please contact your clinician or our office manager serving as the Privacy Officer.

Changes to this Notice. We reserve the right to change our privacy practices and the terms of this Notice, provided such changes are in accordance with applicable laws. If we revise the terms of this Notice, we will post a revised notice at the practice and will make paper copies of this Notice available.